

INCORPORATED VILLAGE OF GARDEN CITY
DEPARTMENT OF PUBLIC WORKS
351 STEWART AVENUE
GARDEN CITY, N.Y. 11530-4528



RIGHT OF WAY PERMIT APPLICATION – ROAD OPENING PERMIT

PERMIT NO. _____

*****MUST GIVE 48-HOUR NOTICE TO SCHEDULE WORK*****
****CALL (516) 465-4005 BETWEEN 8:30 A.M. – 4:30 P.M.****

Applicant: _____
(Business Name)

(Business Address)

(City, State) (Zip Code)

(Contact Name) (Contact Phone) (Contact Email)

The above-named applicant does hereby apply for the issuance of a permit for the following purpose:

Section: _____ Block: _____ Lot(s): _____

Address (Work Location): _____

Total Number of Openings in Each Category:

1-25 SF _____ QTY; 26-50 SF _____ QTY; 51-200 SF _____ QTY; 200+ SF _____ QTY

Trenching: _____ LF Directional Drilling: _____ LF Utility Reference Number: _____

Description of Work: _____

SITE DRAWINGS MUST BE ATTACHED TO PERMIT APPLICATION.

I have read and agree to abide by the Rules & Regulations pertaining to Permit work on and within Village Roads.

Signature: _____ Title: _____ Date: _____

FOR OFFICIAL USE ONLY

THE DURATION OF THE PERMIT HEREBY SOUGHT IS _____ DAYS(S) FROM _____, 20____.

☐ APPROVED ☐ REJECTED

By: _____

Date: _____

Check No.: _____

Fee: \$ _____

Deposit: \$ _____

Total: \$ _____



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER

CONTACT

NAME

PHONE

FAX

E-MAIL

ADDRESS

INSURER(S) AFFORDING COVERAGE

NAIC #

INSURED

Fax No.: 516-742-5377

INSURER A:

INSURER B:

INSURER C:

INSURER D:

INSURER E:

INSURER F:

COVERAGES

CERTIFICATE NUMBER:

REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADD. SUBR. NED. WVD.	POLICY NUMBER	POLICY EFF. (MM/DD/YYYY)	POLICY EXP. (MM/DD/YYYY)	LIMITS
A	☒ COMMERCIAL GENERAL LIABILITY ☐ CLAIMS-MADE ☒ OCCUR GEN'L AGGREGATE LIMIT APPLIES PER ☒ POLICY ☒ PROJECT ☐ LOC ☐ OTHER	Y	Y			EACH OCCURRENCE \$1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000 MED EXP (Any one person) \$ 15,000 PERSONAL & ADV INJURY \$1,000,000 GENERAL AGGREGATE \$2,000,000 PRODUCTS - COMPROP AGG \$2,000,000
A	AUTOMOBILE LIABILITY ☒ ANY AUTO ☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS ☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY	Y	Y			COMBINED SINGLE LIMIT (Ea accident) \$1,000,000 BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)
B	☒ UMBRELLA LIAB ☒ OCCUR ☐ EXCESS LIAB ☐ CLAIMS-MADE ☐ DED ☐ RETENTION \$	Y	Y			EACH OCCURRENCE \$5,000,000 AGGREGATE \$5,000,000
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N N	N/A			☒ PER STATUTE ☐ OTHER E L EACH ACCIDENT E L DISEASE - EA EMPLOYEE E L DISEASE - POLICY LIMIT
A	Professional Liability					
D	NYS Disability					

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101 Additional Remarks Schedule, may be attached if more space is required)

The Incorporated Village of Garden City is included as Additional Insured.

CERTIFICATE HOLDER

CANCELLATION

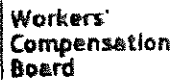
Incorporated Village of Garden City
351 Stewart Avenue
Garden City NY 11530

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

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SAMPLE



**CERTIFICATE OF
NYS WORKERS' COMPENSATION INSURANCE COVERAGE**

www.vob.tv.co.uk

SAMPLE



New York State Insurance Fund

199 CHURCH STREET, NEW YORK, N.Y. 10007-1100

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

***** 111984847

POLICYHOLDER [REDACTED]		CERTIFICATE HOLDER INC. VILLAGE GARDEN 351 STEWART GARDEN	
POLICY NUMBER [REDACTED]	CERTIFICATE NUMBER [REDACTED]	PERIOD [REDACTED]	DATE [REDACTED]

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAME [REDACTED] IS COVERED UNDER THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 472 001-7, COVERING THE OBLIGATION OF THE POLICYHOLDER FOR WORKERS' COMPENSATION UNDER THE NEW YORK WORKERS' COMPENSATION LAW IN ALL OPERATIONS IN THE STATE OF NEW YORK, EXCEPT AS INDICATED ABOVE.

IF YOU WISH TO RECEIVE NOTIFICATION OF CANCELLATIONS, OR TO VALIDATE THE POLICY, VISIT THE WEBSITE [HTTPS://WWW.NYSIF.COM/CERT/CERTVAL.ASP](https://www.nysif.com/cert/certval.asp). THE NEW YORK STATE INSURANCE FUND DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICY.

THE POLICY INCLUDES A WAIVER OF SUBROGATION RIGHTS UNDER WHICH NYSIF AGREES TO WAIVE ITS RIGHT OF SUBROGATION TO BRING A SUIT AGAINST THE POLICYHOLDER TO RECOVER AMOUNTS WE PAID IN WORKERS' COMPENSATION BENEFITS FOR AN EMPLOYEE OF AN INSURED IN THE EVENT THAT, PRIOR TO THE DATE THIS CERTIFICATE HOLDER HAS ENTERED INTO A WRITTEN CONTRACT WITH OUR INSURED, SUCH RIGHT OF SUBROGATION BE WAIVED.

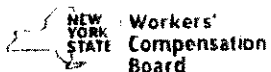
THIS CERTIFICATE IS ISSUED FOR INFORMATION ONLY AND CONFERS NO RIGHTS NOR INSURANCE COVERAGE IN THE CERTIFICATE. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICY.

NEW YORK STATE INSURANCE FUND

[REDACTED]
DIRECTOR, INSURANCE FUND UNDERWRITING



00000000000070760030



CERTIFICATE OF INSURANCE COVERAGE DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

PART 1. To be completed by Disability and Paid Family Leave Benefits Carrier or Licensed Insurance Agent of that Carrier

1a. Legal Name & Address of Insured (use street address only)

[Redacted]

Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e. Wrap-Up Policy)

1b. Business Telephone Number of Insured

[Redacted]

1c. Federal Employer Identification Number or Social Security Number

[Redacted]

2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)

Inc. Village of Garden City
351 Stewart Ave.
Garden City, NY 11530

3a. Name of Insurance Carrier

[Redacted]

3b. Policy Number

[Redacted]

3c. Policy effective period

[Redacted]

4. Policy provides the following benefits

- ☒ A. Both disability and paid family leave benefits
☐ B. Disability benefits only
☐ C. Paid family leave benefits only

5. Policy covers

- ☒ A. All of the employer's employees eligible under the NYS Disability and Family Leave Benefits Law
☐ B. Only the following class or classes of employees: [Redacted]

Under penalty of perjury, I certify that I am an authorized representative of the insurance carrier referenced above and that the named insured has NYS Disability and/or Paid Family Leave Benefits coverage as indicated above.

Date Signed

By

[Redacted Signature]

Telephone Number

IMPORTANT

Boxes 4A and 5A of this form, when signed by the insurance carrier's authorized representative or NYS Licensed Insurance Agent, make this certificate COMPLETE. Mail it directly to the certificate holder.

If Box 4B is checked, this certificate is NOT COMPLETE for purposes of Section 220, Subd. 8 of the NYS Workers' Compensation and Disability Benefits Law. It must be mailed for completion to the Workers' Compensation and Disability Benefits Board, Box 5200, Binghamton, NY 13902-5200.

PART 2. To be completed by the State of New York Workers' Compensation Board (Only if Box 4C or 5B of Part 1 has been checked)

to information maintained by the NYS Workers' Compensation Board, the above-named employer has complied with the Disability and Family Leave Benefits Law with respect to all of his/her employees.

By

(Signature of Authorized NYS Workers' Compensation Board Employee)

Telephone Number

Name and Title

Please Note: Only insurance carriers licensed to write NYS disability and paid family leave benefits insurance policies and NYS licensed insurance agents of those insurance carriers are authorized to issue Form DB-120.1. Insurance brokers are NOT authorized to issue this form.

